TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
AREA METROPOLITAN AMBULANCE

**Respondent Name**
LIBERTY MUTUAL FIRE INSURANCE

**MFDR Tracking Number**
M4-18-0177-01

**Carrier's Austin Representative**
Box Number 01

**MFDR Date Received**
September 20, 2017

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Per DWC rules our service should be reimbursed at least 125% of the Medicare allowable rate."

**Amount in Dispute:** $214.43

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The provider's position statement explains their understanding of the Airline Deregulation Act as requiring reimbursement of air ambulance services at 100% of billed charge. The ACT does not include this requirement for workers' compensation insurance. In the instance of emergency air transport there is not an option of price comparison by the consumer. We are responsible to our customers to insure that reimbursement to providers is made at a fair and reasonable rate. in most cases this rate is mandated by the state fee schedule. The Medicare reimbursement amount is determined based on procedure codes billed and the Zip Code for the point of pick up. A conversion factor of 1.25 is applied in calculating the fair and reasonable reimbursement."

**Response Submitted by:** Liberty Mutual Insurance

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Dispute Amount | Amount Due |
|---|---|---|---|
| March 15, 2017 | Ground Ambulance Transportation, HCPCS code: A0427SH | $214.43 | $214.43 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §134.1 sets out general provisions regarding medical reimbursement.
4. Texas Labor Code §413.011 sets forth general provisions regarding reimbursement policies and guidelines.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
   - P300 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
   - B13 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
   - W3 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCH
   - 193 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.

**Issues**

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

**Findings**

1. The insurance carrier reduced payment for the disputed services with claim adjustment reason codes:

   - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
   - P300 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
   - B13 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
   - W3 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCH
   - 193 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.

   Review of the submitted information finds no documentation to support a negotiated contract between the parties to this dispute. No documentation was presented to support that the disputed services are subject to a contracted fee arrangement. The disputed services are ambulance services for which the Division of Workers' Compensation has not established a medical fee guideline. As there is no applicable contract, fee guideline or legislated fee schedule allowance, the above reduction reasons are not supported.

2. This dispute regards an emergency transport by ground ambulance for which the division has not established a medical fee guideline. The respondent's position letter states that that this is not a network claim and no documentation was found to support that the services are subject to the provisions of a certified workers' compensation health care network.

   The division notes that the respondent's position statement refers to the Airline Deregulation Act and refers to the disputed services as "emergency air transport;" however, the disputed services involve ground ambulance transportation—not air ambulance—and therefore the Airline Deregulation Act is not applicable to the services in dispute.

   Payment is therefore subject to the general medical reimbursement provisions of 28 Texas Administrative Code §134.1(e), which requires that in the absence of an applicable fee guideline or a negotiated contract, medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with a fair and reasonable reimbursement amount as specified in §134.1(f).

3. In the following analysis, the Division examines the positions of both parties and the evidence presented in support of each party's determination of a fair and reasonable payment amount, in order to establish which party presents the best evidence of an amount that will achieve a fair and reasonable reimbursement for the disputed services. The requestor has the burden of proof. The standard of proof required is by a preponderance of the evidence.

   28 Texas Administrative Code §134.1(f) requires that:

   Fair and reasonable reimbursement shall:
   (1) be consistent with the criteria of Labor Code §413.011;
   (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
   (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

The Texas Supreme Court has summarized the statutory standards and criteria applicable to "fair and reasonable" fee determinations as requiring "methodologies that determine fair and reasonable medical fees, ensure quality medical care to injured workers, and achieve effective cost control." *Texas Workers' Compensation Commission v. Patient Advocates of Texas*, 136 *South Western Reporter Third* 656 (Texas 2004).

Additionally, the Third Court of Appeals has held, in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 104 (Texas Appeals – Austin 2003, petition for review denied), that "each . . . reimbursement should be evaluated according to [Texas Labor Code] section 413.011(d)'s definition of 'fair and reasonable' fee guidelines as implemented by Rule 134.1 for case-by-case determinations."

Texas Labor Code §413.011(d) requires that:

> Fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commissioner shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 . . . when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable."

Review of the submitted documentation finds that the requestor's position statement asks for 125% of the Medicare rate as the fair and reasonable methodology for calculating reimbursement for the disputed ambulance services.

While there is no division rule that mandates a 125% conversion factor applied to the Medicare fee schedule for ground ambulance services, this conversion factor has been found to meet the criteria of providing a fair and reasonable reimbursement for professional medical services in the division's Professional Medical Services Fee Guideline at 28 Texas Administrative Code §134.203.

Review of the respondent's position statement finds that the insurance carrier asserts that in calculating a fair and reasonable rate for such services: "The Medicare reimbursement amount is determined based on procedure codes billed and the Zip Code for the point of pick up. A conversion factor of 1.25 is applied in calculating the fair and reasonable reimbursement."

As both the requestor and respondent are in agreement as to the methodology to be used for the calculation of a fair and reasonable reimbursement, the division finds by a preponderance of the evidence that this methodology is supported and will therefore calculate reimbursement based on the methodology mutually advocated by both parties to this dispute.

The Procedure Code in dispute is Ambulance Base Rate HCPCS code A0427 with modifier SH. Based on the ZIP code at the point of pick-up, this area is urban. The Medicare fee for this code in locality 04412-18 is $433.51. 125% of this amount is $541.89. Based on the evidence presented in this dispute, the division finds this to be a fair and reasonable reimbursement for the services in this dispute.

4. The total allowable reimbursement for the services in dispute is $541.89. The insurance carrier has paid $277.86. The requestor is seeking $214.43. The amount due to the requestor is $214.43.

**Conclusion**

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $214.43.

## *ORDER*

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $214.43, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

| | Grayson Richardson | September 29, 2017 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.